IN THE SUPREME COURT

APPEAL FROM THE MICHIGAN COURT OF APPEALS
O'CONNELL, P.C., AND JANSEN AND MURRAY, JJ.

SHIRLEY HAMILTON, as Personal Representative of the Estate of ROSALIE ACKLEY, Deceased,

Plaintiff/Appellee,

v.

BLUE CROSS/BLUE SHIELD OF MICHIGAN

Intervening Plaintiff,

v.

MARK F. KULIGOWSKI, D.O.,

Defendant-Appellant

Supreme Court No: 126275

Court of Appeals No: 244126

Lower Court Case No: 00-033440-NH

APPELLANT'S REPLY BRIEF - - APPELLANT MARK F. KULIGOWSKI, D.O.

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RELY BRIEF OF DEFENDANT/APPELLANT MARK F. KULIGOWSKI, D.O.

ORAL ARGUMENT REQUESTED

PROOF OF SERVICE

TABLE OF CONTENTS

INDEX OF AUTHORITIES

State Cases

State Statutes

ARGUMENT I

THE COURT OF APPEALS AND TRIAL COURT ERRED BY FINDING THAT, WITHIN THE MEANING OF MCLA § 600.2169(1)(a), ARNOLD MARKOWITZ, M.D. (AN INFECTIOUS DISEASE SPECIALIST), SPECIALIZED IN THE "SAME SPECIALTY" AS DEFENDANT/APPELLANT MARK KULIGOWSKI, D.O. (A SPECIALIST IN GENERAL INTERNAL MEDICINE).

Plaintiff's brief fails to interpret the specific criteria adopted by the Legislature in MCLA § 600.2169(1)(a). In order to give the necessary respect to the wording employed by the Legislature, Plaintiff must address the following issues:

> (1) Is a subspecialty considered to be a "specialty" within the meaning of MCLA § 600.2169(1)(a)?
>
> (2) If so, is a subspecialty (in this case infectious disease) "the same" as the primary specialty (in this case general internal medicine)?

Plaintiff's analysis fails on both of these issues.

A. Plaintiff has failed to demonstrate that a subspecialty is not a "specialty" within the meaning of § 600.2169.

As is evident from the following statement in Plaintiff's Brief on Appeal, the thrust of Plaintiff's argument is that a subspecialty is not a specialty, as that term is used in § 600.2169:

> "In daily usage, speakers tend to use imprecise language and shortened terminology by dropping the prefix 'sub' from the phrases 'sub-specialty' and 'sub-specialist' and use instead only the term 'specialty' or 'specialist.' This common use of imprecise terminology does not changed [sic] a 'sub-specialty' into a 'specialty' nor does it change the fact that the Legislature used only the precise term 'specialty' in MCL 600.2169; MSA 27 A.2169." (Brief of Plaintiff-Appellee, page 11).

This quote is particularly interesting because the Plaintiff expressly confirms that, in daily and common usage, the terms "specialty" and "specialist" are employed to refer to

"subspecialty" and "subspecialist." Nonetheless, Plaintiff asks this Court to ignore this daily and common usage as being "imprecise." The Plaintiff asks this Court to ignore the central tenet of statutory interpretation, i.e., that undefined statutory terms must be given their common and generally accepted meanings. *Bailey v. Oakwood Hospital and Medical Center*, 472 Mich 685, 692-693, 698 NW2d 374, 379 (2005); *Koontz v. Ameritech Services, Inc.*, 466 Mich 304, 312, 645 NW2d 34, 39 (2002). Plaintiff's interpretation of § 600.2169 cannot be accepted without abandoning both the accepted principles of statutory construction, and this Court's constitutional duty to apply the unambiguous plain meaning of a statute. *Mayor of City of Lansing v. Michigan Public Service Commission*, 470 Mich 154, 161, 680 NW2d 840, 844 (2004); *Koontz v. Ameritech Services, Inc.*, 466 Mich 304, 312, 645 NW2d 34, 39 (2002). As such, Plaintiff's interpretation of § 600.2169 lacks any proper legal foundation and must be soundly rejected.

The Plaintiff also cites several dictionary definitions of the term "specialty" in an unsuccessful effort to show that this term does not encompass the term "subspecialty". The definitions offered by the Plaintiff are:

> (1) Definition of "specialty": "[t]he branch of medicine, surgery, dentistry, or nursing in which a specialist practices". *Taber's Encyclopedic Medical Dictionary (20th Edition)* (Brief of Plaintiff/Appellee at page 9.
>
> (2) Definition of "specialist": "a physician or other health professional who has advanced education and training in one clinical area of practice. *Taber's Encyclopedic Medical Dictionary (20th Edition)* (Brief of Plaintiff/Appellee at pages 9-10).
>
> (3) Definition of "specialist": "[o]ne who devotes professional attention to a particular specialty or subject area. *Stedman's Medical Dictionary (26th Edition)* (Brief of Plaintiff/Appellee, page 10).
>
> (4) Definition of "specialist": "a medical practitioner who deals only with a particular class of diseases, conditions, patients, etc." *Random House Webster's College Dictionary (1997)* (Brief of) Plaintiff/Appellee, at page 10).

None of these definitions supports Plaintiff's argument. Quite the contrary, each of these definitions can just easily be applied to the terms "subspecialty" and "subspecialist". None of the definitions support the notion that the term "specialty" can only be properly applied to the most generalized and primary level of specialization.

Plaintiff also places considerable emphasis on the fact that § 600.2169 uses the terms "specialty" and "specialist," but never uses the terms "subspecialty" and "subspecialist." The Plaintiff further notes that other Michigan statutes explicitly acknowledge the existence of both specialties and subspecialties. On this basis, the Plaintiff concludes that the failure to mention subspecialties and subspecialists in § 600.2169 reflects a deliberate legislative decision not to require matching subspecialties. The Plaintiff's reasoning is, however, highly tenuous. The intent of the Legislature must be gathered from the words that the Legislature actually used, not from its silence. *Devillers v. Auto Club Insurance Association*, 473 Mich 562, 592 fn 66, 702 NW2d 539, 557 fn 66 (2005); *Donajkowski v. Alpena Power Company*, 460 Mich 243, 261, 596 NW2d 574, 583 (1999). In this case, the Plaintiff has conceded that, in daily and common usage, the terms "specialty" and "specialist" are used to refer to "subspecialty" and "subspecialist." This Court is, of course, obligated to apply the commonly accepted meaning of legislative terminology. The Plaintiff can, therefore, draw no support from the fact that MCLA § 600.2169 does not use the terms "subspecialty" and "subspecialist." There was simply no reason for the Court to use these terms, because they are encompassed within the commonly accepted meaning of the terms "specialty" and "specialist."

Contrary to what the Plaintiff claims, Defendant Kuligowski's interpretation of the terms "specialty" and "specialist" do not contradict this Court's holding in *Halloran v. Bhan*, 470 Mich 572, 683 NW2d 129 (2004). The Plaintiff makes a deductive leap by claiming that, in *Halloran*, the Defendant and Plaintiff's expert practiced the same subspecialties. In *Halloran*, Plaintiff's

expert and the Defendant practiced different primary specialties. The Defendant was a board certified internal medicine specialist, and Plaintiff's expert was a board certified anesthesiologist. Moreover, the expert's primary specialty of anesthesiology was not relevant to the issues in that case. As this Court acknowledged, "This is not a case in which the administration of anesthetic is at issue." *Halloran*, at 575 fn 1. This Court also noted that the Defendant was practicing internal medicine, not anesthesiology at the time of the alleged malpractice, and that internal medicine was relevant to the alleged malpractice. *Halloran*, *supra*, at 577 fn 5. Even more importantly, this Court did not conclude that the subspecialty of critical care medicine was identical for both internist and anesthesiologist. Quite the contrary, this Court raised a serious question as to whether the practice of critical care medicine may be different depending on the physicians' underlying specialty:

> "Consider the facts of *this case*: there may be an enormous difference between critical care as practiced by an *internist* and critical care as practiced by an *anesthesiologist*. Indeed, one would expect that a patient requiring a medical diagnosis during critical care would rather be treated by an internist than an anesthesiologist. Likewise, one would expect that a patient being anesthetized during critical care would rather be treated by an individual trained in anesthesiology than one trained in internal medicine. Thus, the practice of critical care may be quite different depending on the physician's underlying specialization." *Halloran v. Bhan*, *supra*, at 579 fn 7.

Nothing in *Halloran* suggests that the standards, training and nature of treatment is identical for critical care specialists, regardless of whether they are internists or anesthesiologists. In short, the Defendant and Plaintiff's expert clearly practiced different underlying specialties, and this Court was not satisfied that the subspecialty of critical care medicine was "the same" for both internists and anesthesiologist. Consequently, Defendant Kuligowski's interpretation of § 600.2169 does not in any way contradict this Court's holding in *Halloran*.

B. Plaintiff has failed to demonstrate that the specialty of infectious disease is "the same" as the specialty of general internal medicine.

Although the Plaintiff concedes that the term "same" means "not different", she gives scant attention to the issue whether the specialty of infectious disease is "not different" or "the same" as the specialty of general internal medicine. Overall, however, Plaintiff seems to claim that infectious disease is a branch of internal medicine and therefore these two specialties are the same. (Brief of Plaintiff/Appellee at page 5). This reasoning is, however, a non-sequitur. By its very nature, a subspecialty has a narrower scope than the more general specialty from which it is derived. Standing alone, this difference in scope justifies the conclusion that infectious disease is not the same general internal medicine. As discussed in the initial brief of Defendant/Appellant, however, the differences do not end there. Rather, these two specialties have differences in training and nature of patient population. (Brief on Appeal of Defendant/Appellant, at pages 18-19). In the face of these substantial differences, the Plaintiff cannot credibly argue that these two specialties are identical.

ARGUMENT II

THE COURT OF APPEALS CLEARLY ERRED BY HOLDING THAT A BOARD CERTIFIED INTERNIST WHO ADMITTEDLY SPENT MORE THAN 50% OF HIS ACTIVE CLINICAL PRACTICE IN THE SPECIALTY OF INFECTIOUS DISEASES WAS QUALIFIED PURSUANT TO MCLA § 600.2169(1)(b)(i) TO OFFER EXPERT TESTIMONY AGAINST DEFENDANT/APPELLANT KULIGOWSKI, A BOARD CERTIFIED INTERNIST, AS TO AN INTERNAL MEDICINE ISSUE WHICH DID NOT INVOLVE INFECTIOUS DISEASES AND/OR IN HOLDING THAT IN ENACTING MCLA § 600.2169(1)(b)(i), THE LEGISLATURE INTENDED THAT THE COURT LOOK NO FURTHER THAN THE BROAD "SPECIALTY" OF THE EXPERT AND DEFENDANT, IGNORING WHETHER THE ACTIVE CLINICAL PRACTICE OF THE PROFFERED EXPERT FALLS WITHIN THE SAME "SUB-SPECIALTY" OF THAT BROAD "SPECIALTY" AS THE PRACTICE OF THE DEFENDANT AT ISSUE IN THE CASE.

Plaintiff's Argument II is merely an extension of Plaintiff's Argument I. In other words, Plaintiff claims that infectious disease is a branch of internal medicine, and therefore the active clinical practice of infectious disease constitutes the active clinical practice of general internal medicine. This argument has already been fully addressed in Defendant/Appellant's original Brief on Appeal, as well as the preceding section of this Brief. Accordingly, this argument need not be addressed in detail at this point.

The Plaintiff also claims (without support in the record) that many officers of the American Board of Internal Medicine possess sub-specialty certifications, that the current Chair of the Board is certified in critical care and pulmonology, and that the Chair-Elect is certified in infectious disease. (Brief of Plaintiff/Appellee, at page 20). On this basis, Plaintiff argues that Defendant's interpretation of §1 600.2169 would lead to the allegedly "absurd" result of disqualifying these board officers from testifying regarding the standard of practice applicable to general internists. Although Plaintiff's statements are not based on the record of this case, and should therefore be rejected for this reason, Plaintiff's argument must also be rejected on substantive grounds. The issues on this appeal pertain to the proper interpretation of § 600.2169. The proper interpretation of this statute is not governed by the shifting composition of the American Board of Internal Medicine. Rather, as in any case of statutory interpretation, the Courts must apply the commonly understood meaning of the statutory language. If the commonly understood meaning is unambiguous, the Courts cannot look for meaning beyond the actual text of the statute. As demonstrated by Defendant/Appellant's original brief, the term "sub-specialty" is encompassed within the plain meaning of the term "specialty." It is simply unnecessary to look any further for the meaning of this term.

As a corollary to this Court's focus on the statutory text, this Court has rejected the so-called "absurd result" rule of statutory construction. *People v. McIntire*, 461 Mich 147, 155-160,

599 NW2d 102 (1999). Thus, in the instant case, the plain meaning of the term "specialty" is unambiguous, and there is absolutely no legal basis for application of the "absurd result" rule of statutory construction.

Furthermore, Defendant/Appellant does not agree that his interpretation of §600.2169 would lead to absurd results. Quite the contrary, Plaintiff/Appellee's interpretation of this statute would lead to monumentally absurd results. Pursuant to Plaintiff's interpretation of this statute, any general internal medicine specialist would be allowed to testify regarding the standard of practice applicable to any sub-specialty of internal medicine. Thus, a general internal medicine specialist would be allowed to testify regarding the standard of practice applicable to specialists in such varied fields as cardiology, critical care medicine, endocrinology, gastroenterology, hematology, infectious disease, oncology, nephrology, pulmonology, and rheumatology. Even more incongruous is that Plaintiff's interpretation of this statute would allow any of these sub-specialists to testify regarding the standard of practice applicable to any of the other sub-specialties of internal medicine. Thus, a sub-specialist in rheumatology would be allowed to testify regarding the standard of practice applicable to a cardiologist, a gastroenterologist would be allowed to testify regarding the standard of practice applicable to a pulmonologist, and so on. Contrary to what the Plaintiff asserts, it is the Plaintiff's interpretation of § 600.2169 which would lead to an absurd result.

RELIEF

For all of the foregoing reasons, Defendant/Appellant Kuligowski prays that this Honorable Court issue an Opinion and Order reversing the April 22, 2004 Opinion of the Court of Appeals, reinstating the trial court ruling that Arnold Markowitz, M.D. is unqualified to testify regarding the standard of practice applicable to Defendant/Appellant Mark Kuligowski, D.O., and reinstating the order of directed verdict entered by the trial court.

Respectfully Submitted,

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Dated: October 31, 2005